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Ibogaine: Potential for Application in Drug Addiction Treatment

by Jon

Drugs have been a part of human society for at least as long as there has been recorded history. Opiates--the class of natural and synthetic drugs whose molecular structure resembles the psychoactive constituents found in the resin of the unripe seed pods of the opium poppy (*Papavera somniferum*)--have been in use by humans since at least the 5th Century BCE, and have been used recreationally for about 600 years (WWW1); because opiates boast such a high potential for both physical and psychological dependence, it is safe to assume that opiate addiction and abuse has been a part of human society for 600 years or longer. During the last several decades, a plurality of drug treatment programs have arisen, all claiming to be able to help a willing addict stop his or her opiate use. Many opiate addiction treatment programs involve the use of synthetic or semi-synthetic opiates (e.g. methadone or buprenorphine) to create "replacement addictions," and gradually "wean" the user off more dangerous opiates (e.g. diacetylmorphine) gradually reducing opiate intake, ideally to zero. Success with these opiate maintenance programs has been mixed, and some persisting problems--such as the fact that both methadone and buprenorphine have considerable abuse potentials of their own--have led to some skepticism as to whether or not such programs are really effective at combating addiction. In the last ten years, a new opiate addiction treatment has received attention in scientific, medical, and drug using communities. The treatment involves the use of a compound known as ibogaine, naturally occurring indole alkaloid found in the rootbark of *Tabernanthe iboga*, a plant native to Central Africa (WWW2). The

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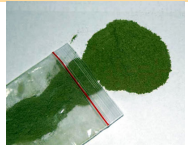
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mechanisms by which ibogaine acts to make it an effective detoxification tool are not fully understood, but both anecdotal reports and several scientific studies indicate that ibogaine is indeed effective at combating addiction to opiates, and may also help combat addictions to other drugs, such as cocaine and amphetamines.

Ibogaine, because of the novel mechanism by which it helps to facilitate the cessation of addictive habits, has considerable potential as a powerful tool for those seeking to end problematic relationships with opiates, and perhaps other substances as well. The compound itself was only recently introduced to Western scientific medicine, but has centuries of documented use among the Bwiti tribe in central Africa (WWW2). At lower doses, ibogaine has the ability to increase energy and mental alertness in users, as well as to decrease the desire for food and drink, and so is used by the Bwiti as a mild stimulant and hunting aid. However, at higher doses (20+ mg/kg) ibogaine has much more significant psychoactive properties, and is used ritualistically in initiation rites for its potent hallucinogenic properties (Mash et al. 2000).

Ibogaine was first introduced as a potential treatment for opiate addiction by Howard Lotsof, who took the drug in 1962 looking for a psychedelic experience, and awoke 30 hours later with no cravings and no withdrawal symptoms, despite being a heavy heroin user at the time (De Rienzo et al. 1997). Mr. Lotsof developed and maintained an ibogaine maintenance program for himself, which he followed for three years, and was able to remain opiate free for that amount of time. He did relapse several years later, becoming readdicted to heroin for a year and a half, but was able to detoxify himself again thanks, in part, to his experiences with ibogaine (WWW4). In 1986, Mr. Lotsof opened a company by the name of NDA International to advocate for the use and research of ibogaine and its active constituents as anti-addictive compounds.

In large doses, ibogaine can put the user into a deep trance-like state, in which intense open and closed eye visualizations are manifest, lasting for 20 or more hours; the trance is often fully immersive, and described by users as a "journey" (WWW4). The power and intensity of the visualizations seems to resemble those experienced by users of dimethyltryptamine. Because of these potent psychoactive effects,

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ibogaine was put into Schedule I--a category of substances which have a high potential for abuse and no recognized medical application--by the United States government in 1966, along with other more well known hallucinogens, such as LSD and psilocybin. After ibogaine was scheduled, Howard Lotsof and his associates traveled to Holland where, between 1962 and 1963, they administered ibogaine to 20 subjects, in an attempt to ascertain whether or not it did indeed possess novel anti-addictive properties. Of these 20 subjects, 7 were heroin dependent, and Lotsof noted that all reported a dimishment of withdrawal symptoms and craving after ingesting ibogaine. Additionally, 5 of these 7 individuals were able to maintain abstinence from heroin for 6 months or longer. (WWW3).

Ibogaine has several properties that make it unique among anti-addictive compounds. Paramount among these unique attributes is ibogaine's ability to not only reduce or completely eliminate craving for a drug, but also to completely nullify withdrawal symptoms. Opiate withdrawal is notoriously painful and generally unpleasant and, while generally not fatal, is often so severe as to drive even the most committed addicts under treatment to relapse simply to achieve relief from the withdrawal symptoms. This--the ability of ibogaine treatment to virtually nullify withdrawal symptoms in 90% of patients--is one of its most important properties as a potentially anti-addictive compound (WWW2). Approximately 30 hours after beginning a session with ibogaine, most patients wake up from a deep sleep feeling refreshed and ravenously hungry (De Rienzo, et al. 1997). As opiate withdrawal is characterized in part by gastrointestinal discomfort--opiates have a marked effect on the smooth muscles of the gastrointestinal tract, and when opiates are rapidly cleared from the body nausea, diarrhea, and vomiting often result--requesting and then eating a large meal less than 2 full days after a final opiate dose is virtually unheard of outside of ibogaine treatment programs. The ability of ibogaine to attenuate withdrawal symptoms has been confirmed with animal study. Morphine dependent rats, when given the opiate receptor antagonist naloxone, experience withdrawal symptoms characterized by increased rearing, digging, jumping, salivation and head shaking. Ibogaine dosing (40 mg/kg) greatly reduced the frequency and severity of these symptoms (Popik & Skolnick 1998).

The mechanism by which ibogaine is able to function as an anti-addictive compound is not completely understood, but it is likely a combination of physiological/pharmacological effects and psychological effects. Users of ibogaine report vivid hallucinations, and are often given the impression that they have been given the opportunity to review all the "watershed" moments in their lives--that is, that they are able to see every crucial decision they have made, as well as all alternative options that they could have chosen (WWW5). The drug is regarded as oneirogenic (i.e. it induces lucid dreamlike sequences), and allows users to relive repressed memories--users often describe the quality of these memories as being so intense so as to resemble watching a film--but without the emotional baggage that generally accompany such repressed memories. This allows the ibogaine user to gain perspective on past decisions and events--such as those which led to the user's drug problem--and to see what could be done to amend bad decisions. In addition, ibogaine does not cause "thought disturbances," or the radical changes in thought patterns that often characterize classical hallucinogens, such as LSD or psilocybin, meaning that the subject remains free to utilize his or her rational capacity to analyze the "visions" induced by the ibogaine, and to draw logical conclusions from those visions.

As with all psychoactive drugs, ibogaine's pharmacology is complicated and not fully understood. After the 1992 death of a female heroin addict under ibogaine treatment in Holland, government sponsored research into ibogaine and its constituent alkaloids as possible anti-addictive substances all but stopped (WWW2). Although ibogaine toxicity is not blamed for the death--it was later determined that the woman had been surreptitiously smoking opium during the treatment--the FDA and other licensing agencies became much less interested in allowing human research to continue. However, recent animal trials have shown that ibogaine and its constituent alkaloids do have a measurable effect on desire for opiates, cocaine, amphetamines, and even nicotine. A study conducted by Maisonneuve & Glick in 2003 demonstrated that 18-Methoxycoronaridine (18-MC), an ibogaine alkaloid congener, "reduced intravenous morphine, cocaine, methamphetamine and nicotine self-administration, oral alcohol and nicotine intake, and attenuated signs of opioid withdrawal, but had no effect on responding for a

nondrug reinforcer (water) and produced no apparent toxicity" (Maisonneuve & Glick 2003). A similar study, conducted by Cappendijk & Dzoljic found that rats trained to intravenously self-administer cocaine decreased cocaine intake by 40-60% for several days following a single dose of ibogaine (40 mg/kg), and that repeated administration of similar dose levels at one-week intervals decreased cocaine self-administration by 60-80%. This decrease was maintained for several weeks (Popik & Skolnick, 1998). It is currently believed that ibogaine's function as an N-methyl-D-aspartate (NMDA) receptor antagonist, and that this action is responsible for its anti-addictive properties, but precisely how this receptor is involved in addiction and withdrawal is still under study (Popik & Skolnick, 1998); the issue of ibogaine's exact neuropharmacology is further complicated by the fact that it is also active at several other important receptors, including kappa and mu opiate receptors, serotonin receptors, dopamine receptors, sigma receptors, making it difficult to draw a concrete conclusion as to how exactly ibogaine functions as an anti-addictive compound (WWW2). Ibogaine's primary metabolite, noribogaine, has also been indicated in ibogaine's anti-addictive properties. Urinalysis of subjects undergoing ibogaine treatment show that noribogaine remains in the human body for much longer than ibogaine, and that it has an even higher affinity for opiate receptors than its parent compound. This indicates that noribogaine may also play an important role in ibogaine's anti-addictive effects (Mash et al. 2000).

Ibogaine obviously has important anti-addictive properties that are worthy of study. The reluctance on the part of the FDA and other agencies to licence study because of ibogaine's psychoactivity is likely just a smoke-screen for other, more political reasons: many medications, including those sold OTC, contain components which are just as psychoactive as ibogaine (i.e. dextromethorphan, ephedrine, anti-histamines, etc). Ibogaine has the potential to revolutionize drug abuse therapy, though it is by no means a "magic bullet" to end drug addiction; studies have shown that only about 25% of subjects remain drug free following an ibogaine session if no followup therapy is applied, as compared with 50% of subjects who also received counseling, or other forms of therapy (Popick and Solnick 1998). However, ibogaine has the potential to be a powerful tool to combat drug

addiction, and certainly merits further research.

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